Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Public Report

Report Issue Date: April 17, 2025
Inspection Number: 2025-1049-0002
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Scarborough, Scarborough

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 9-11, 14-17, 2025

The following intake(s) were inspected:
- Intake: #00141831 – [Critical Incident (CI): 2117-000007-25] – related to a disease outbreak
- Intake: #00144216 – [CI: 2117-000015-25] – related to improper care of a resident

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a planned care intervention was included in a resident's written plan of care related to a specialized device.

A resident was admitted to the home with a specialized device. There were no care interventions included in the resident's written plan for this device.

Sources: Resident ’s clinical notes; home’s investigation notes; and interviews with a Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed related to their bathing

preference.

Documentation revealed a resident expressed a different bathing preference than what was indicated in their plan of care. An interview with the resident confirmed they wanted their bathing preference changed. However, the plan of care was not reviewed or revised to reflect their current preference.

Sources: Resident's clinical records; and interview with the resident.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure a resident was protected from neglect when they failed to complete assessments, treatments and monitoring of the resident's wound.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

The resident had an alteration in skin condition. Record reviews and staff interviews revealed that there was no weekly skin assessments completed for the resident. In

addition, there was no identified plan of care for treatments, interventions, or monitoring specified for the management of the resident's skin condition. Due to the inaction of the licensee, the resident's health, safety and well-being was put at risk.

Sources: Resident's clinical notes; home's investigation notes; and interviews with the resident, RPN, Assistant Director of Care (ADOC) and Senior Director of Care (DOC).